Name: _____ **Age:**_____
Sex:_____ **Date:** _____**SSN:**_____

1. Please describe your symptoms:

2. When did these symptoms begin?

3. Did your symptoms come on gradually or suddenly?

4. Have symptoms become worse (more frequent or more severe?) or have they improved?

5. My dizziness is constant. YES NO (circle one)

6. My dizziness is in attacks. YES NO (circle one)
   How often?_____
   How long?_____

7. Check all that apply to your **dizzy spells**.
   - ❑ Preceded by flu or cold
   - ❑ Free from dizziness between attacks
   - ❑ Nausea
   - ❑ Lightheadedness
   - ❑ Dizzier in certain positions_____
   - ❑ Fullness, pressure, or ringing in your ears
   - ❑ Imbalance

8. Are you completely free of dizziness between attacks? YES NO

9. Do you have trouble walking in the dark? YES NO

10. Do you know anything that will:
    Stop you dizziness or make it better?_____
    Make your dizziness worse?_____
    Precipitate an attack?_____

11. Check all that apply to **other sensations you may have**:

- ❑ Blacking out or fainting when dizzy
- ❑ Dizzy or unsteady constantly
- ❑ Severe or recurrent headaches
- ❑ Double or blurry vision
- ❑ Numbness in face or extremities
- ❑ Weakness or clumsiness in arms, legs
- ❑ Slurred or difficult speech
- ❑ Difficulty swallowing
- ❑ Tingling around mouth
- ❑ Spots before eyes
- ❑ Jerking of arms and legs
- ❑ Confusion or memory loss
- ❑ Dizzy when stand up quickly
- ❑ Weakness/ faintness a few hours after eating

12. Do you have any of the following symptoms?

- ❑ Difficulty hearing both ears right only left only
  - o When did it start_____
- ❑ Noise in your ears both ears right only left only
  - o Describe the noise_____
- ❑ Does the noise change with dizziness? Yes No
  - o If yes, please describe_____
- ❑ Pain in your ears both ears right only left only
- ❑ Discharge from you ears both ears right only left only

13. Check all that apply to your **medical history**:

- ❑ Head injury with loss of consciousness
- ❑ Allergies
  - Medicines: _____
  - Other: _____
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Mental illness
- ❑ Back or neck injury
- ❑ Arthritis
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Heart disease
- ❑ Asthma
- ❑ Migraine headaches
- ❑ Stroke
- ❑ Seizure
- ❑ Other:_____

14. Were you exposed to any irritating fumes at the onset of dizziness? YES NO

15. Have you ever injured your head or neck? YES NO

16. Check those that **may to be linked to your dizziness:**

- ❑ Stress
- ❑ Menstrual period
- ❑ Overwork or exertion
- ❑ Headaches
- ❑ Diet
- ❑ Recent change in eye glasses

17. Check all that apply to your **habits and lifestyle**:

- ❑ Drink coffee
  How much? _____
- ❑ Drink tea
  How much? _____
- ❑ Drink soft drinks
  How much? _____
- ❑ Drink alcohol
  How much? _____
- ❑ Smoke
  How much? _____

18. Please list your **current medical problems and length of illness.**

19. Please list all **surgeries and approximate dates.**

20. Please list **all medicines** you currently take, including all over-the-counter, herbal, street, and alternative products.

21. Have you had any of the above medicines in the past 48 hours?

22. What **studies** have been done previously (hearing tests, head scans, blood work, etc.)?

_____ _____

Patient Signature Date